CHAPTER IV - INTERMEDIARY PAYMENT AND REIMBURSEMENT

PAYMENT OF AMBULANCE SERVICES

OBJECTIVE

The objective of this chapter is to provide the information that is needed to compute the payment due to Medicare providers for ambulance services.

Participants will learn the following in the course of this chapter:

1. The ambulance fee schedule will be phased in over a five-year transition beginning with the implementation of the fee schedule.

2. Payment rates will be made based on seven RVUs (Relative Value Units) for ground ambulance services and two payment rates for air ambulance services with an additional payment for mileage in each case.

3. Services provided in a rural area qualify for an increased adjustment.

OVERVIEW

AMBULANCE FEE SCHEDULE

Ambulance Fee Schedule

- **Mechanisms to control increases in expenditures**
- **Payments made based on service provided**
- **Payments adjusted for inflation**
- **Five-year phase-in of fee schedule (calendar)**
- **Services made on assignment basis**

Section 4531(b)(2) of the Balanced Budget Act (BBA) of 1997 added a new section 1834(l) to the Social Security Act which mandates implementation of a national fee schedule for ambulance services furnished as a benefit under Medicare Part B. This section requires that in establishing the ambulance fee schedule, CMS will:

- Establish mechanisms to control increases in expenditures for ambulance services under Part B of the Medicare program;
- Establish definitions for ambulance services that link payments to the type of service furnished and are appropriate for the beneficiary's condition;
- Consider appropriate regional and operational differences;
- Consider adjustments to payment rates to account for inflation and other relevant factors;
- Phase in the fee schedule in an efficient and fair manner; and,
- Require payment for ambulance services be made only on an assignment-related basis.

Ambulance Fee Schedule applies to:

- **All public or private**
- **For profit or not-for-profit**
- **Volunteer**
- **Government-affiliated**
- **Institutionally affiliated**
- **Wholly independent suppliers**

In addition, the BBA requires that ambulance services covered under Medicare be paid based on the lower of the actual billed charge or the ambulance fee schedule amount.

The ambulance fee schedule applies to all entities that furnish ambulance services, regardless of type. All public or private, for profit or not-for-profit, volunteer, government-affiliated, institutionally affiliated or owned, or wholly independent supplier ambulance companies, however organized, would be paid according to this ambulance fee schedule.

IMPLEMENTATION METHODOLOGY

Ambulance claims from providers are currently paid based on the provider's interim rate (which is a percentage based on the provider's historical cost-to-charge ratio multiplied by the submitted charge) and then cost-settled at the end of the provider's fiscal year subject to a cost per trip limit.

- **Paid based on the provider's interim rate**
- **Cost-settled at end of the provider's fiscal year via Medicare cost report.**

The proposed ambulance fee schedule is to be phased in over a five-year period. Therefore, for dates of service (DOS) in the first year of transition, providers will be paid based on 80 percent of the current payment allowance (as described in Program Memorandum AB-99-73) plus 20 percent of the ambulance fee schedule amount.

The ambulance fee schedule will be implemented as follows:

Transition Year	Former Payment %	Fee Schedule %
1	80	20
2	60	40
3	40	60
4	20	80
5	0	100

Currently, provider claims are paid based on the provider's interim rate and are cost settled at the end of the provider's fiscal year. Program payments are subject to a limit based on the statutory ambulance inflation factor applied to the provider's cost per ambulance trip.

The fee schedule transition will be phased in on a calendar year basis. Therefore, for providers that file cost reports on other than a CY basis, two different blended rates would apply.

Effective for services furnished during 2002 on or after April 1, the proposed blended amount for provider claims would equal the sum of 80 percent of the current payment system amount and 20 percent of the ambulance fee schedule amount. The intent of implementing payment under the fee schedule at only

20 percent in 2002 is to give ambulance providers a period of time to adjust to the new payment amounts, since some providers may receive substantially lower payments than they do now.

The Program's payment in all cases would be subject to the Part B coinsurance and deductible requirements.

NEW PROVIDERS

Since new providers would not have a cost per trip limit from the prior year, there would not be a cost per trip inflation limit applied to new providers in their first year of furnishing ambulance services.

Seven Categories of Ground Service

1. **Basic Life Support (BLS)**
2. **Basic Life Support – Emergency (BLS-E)**
3. **Advanced Life Support, Level 1 (ALS1)**
4. **Advanced Life Support Level 1 – Emergency (ALS1-E)**
5. **Advanced Life Support, Level 2 (ALS2)**
6. **Specialty Care Transport (SCT)**
7. **Paramedic Intercept (PI) (carrier only)**

NINE CATEGORIES OF AMBULANCE SERVICES

Nine categories of ambulance services are reimbursable under the new fee schedule. There are seven ground and two air:

GROUND AMBULANCE

1. Basic Life Support (BLS)
2. BLS – Emergency
3. Advanced Life Support, Level 1 (ALS1)
4. ALS1 - Emergency
5. Advanced Life Support, Level 2 (ALS2)
6. Specialty Care Transport (SCT)
7. Paramedic Intercept (PI) (carrier only)

Two Categories of Air Ambulance

1. **Fixed Wing Air Ambulance (FW)**
2. **Rotary Wing Air Ambulance (RW)**

AIR AMBULANCE

There are two categories of air ambulance services to distinguish fixed wing from rotary wing (helicopter) aircraft.

Mileage is expressed in statute (ground miles) not nautical miles. The mileage rate will be calculated per actual loaded (patient onboard) miles flown.

1. Fixed Wing Air Ambulance (FW)
2. Rotary Wing Air Ambulance (RW)

EMERGENCY RESPONSE ADJUSTMENT FACTOR

Emergency Response Adjustment Factor

- **Assignment of higher RVUs**
- **Only applicable to BLS and ALS1 services**

An ambulance service that qualifies as an emergency response service will be assigned higher RVUs to recognize the additional costs incurred for readines to respond immediately to an emergency call.

An immediate response is defined as one in which the ambulance provider begins as quickly as possible to take the steps necessary to respond to the call.

The emergency response adjustment factor does not apply to PI, ALS2, SCT, FW, or RW.

MULTIPLE PATIENTS

If an ambulance transports more than one patient at a time, payment will be prorated based on the ambulance fee schedule by the number of the patients in the ambulance. If two patients are transported simultaneously, for each Medicare beneficiary, the payment allowance is equal to 75 percent of the allowed amount for the level of medically appropriate service furnished to the beneficiary.

If three or more patients are transported simultaneously, then the payment allowance for the Medicare beneficiary (or each of them) is equal to 60 percent of the service payment allowance applicable for the level of care furnished to the beneficiary.

However, a single payment allowance for mileage will continue to be prorated by the number of patients (Medicare and non-Medicare) onboard.

The Medicare Part B assignment rules apply to these prorated amounts.

Pronouncement of Death

- **3 scenarios apply**
- **Payment is contingent upon when the beneficiary is pronounced dead in relationship to when the ambulance is called**

PRONOUNCEMENT OF DEATH

There are three scenarios that apply to ambulance services and the pronouncement of death:

1) The beneficiary is pronounced dead prior to the time that the ambulance is called; no payment would be made,

2) The beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene; payment for an ambulance trip will be made at the BLS rate, but no mileage will be paid, or

3) If the beneficiary was pronounced dead after being loaded into the ambulance, full payment will be made.

Multiple Arrivals

- **Medicare will make payment to the entity that provides transportation for the beneficiary**
- **If more than one entity provides services, negotiation of payment must be made between providers**

MULTIPLE ARRIVALS

When multiple units respond to a call, Medicare will pay the entity that provides the transportation for the beneficiary. The transporting entity will bill Medicare.

For example: If BLS and ALS entities respond to a call and the BLS entity furnishes the transportation after an ALS assessment is furnished, the BLS entity would bill Medicare using the ALS1 rate. The ALS unit would not be entitled to bill Medicare since they did not provide the transport.

COMPONENTS OF THE FEE SCHEDULE

GROUND AMBULANCE SERVICES

Conversion Factor (CF)

The CF is a money amount used to develop a base rate for each category of ground ambulance service. The CF will be updated by CMS as necessary.

Relative Value Units (RVUs)

RVUs set a numeric value for ambulance services relative to the value of a base level ambulance service. Since there are marked differences in resources necessary to furnish the various levels of ground ambulance services, different levels of payment are appropriate for the various levels of service.

The different payment amounts are based on levels of service. An RVU expresses the constant multiplier for a particular type of service (including, where appropriate, an emergency response). An RVU of 1.00 is assigned to the BLS of ground service, i.e., BLS has an RVU of 1; higher RVU values are assigned to the other types of ground ambulance services, which require more services than BLS.

The service levels and their associated RVUs are listed below.

Service Level	RVU
BLS	1.00
BLS – Emergency	1.60
ALS1	1.20
ALS1 – Emergency	1.90
ALS2	2.75
SCT	3.25
PI	1.75

Geographic Adjustment Factor (GAF)

The location where the beneficiary was put in the ambulance ("point of pickup") establishes which GPCI applies.

The GAF is one of two factors intended to address regional differences in the cost of furnishing ambulance services.

The GAF for the ambulance schedule uses the non-facility practice expense (PE) of the geographic practice cost index (GPCI) of the Medicare physician fee schedule to adjust payment to account for regional differences. Thus, the geographic areas applicable to the ambulance fee schedule are the same for those used for the physician fee schedule.

The location where the beneficiary was put in the ambulance ("point of pickup") establishes which GPCI applies. For multiple vehicle transports, each leg of the transport is separately evaluated for the applicable GPCI. Thus, for second (or any subsequent) leg of a transport, the point of pickup establishes the applicable GPCI for that portion of the ambulance transport.

For ground ambulance services, the applicable GPCI is multiplied by 70% of the base rate. The base rate for each category of ground ambulance service is the CF multiplied by the applicable RVU. For air ambulance services, the applicable GPCI is multiplied by 50% of the base rate. The GPCI is not applied to the mileage rate in any case.

The physician fee schedule law requires that the GPCI be updated every 3 years. The latest revision was effective January 1, 2001. These were published in the November 1, 2000 Federal Register (65 FR 65585).

Services furnished in Rural Areas:

- **Increased adjustment applies**
- **Rural designation is made at the time the beneficiary is placed on the ambulance**

SERVICES FURNISHED IN RURAL AREAS

Payment is increased for ambulance services that are furnished in rural areas. This adjustment is made to cover the additional cost per ambulance trip of isolated, essential ambulance providers, for which there are not many trips furnished over the course of a typical month because of a small rural population.

The definition of a rural area is an area outside a Metropolitan Statistical Area (MSA) or a New England County Metropolitan Area, or an area within an MSA identified as rural using the Goldsmith modification. The application of the rural adjustment will be determined by the geographic location at which the beneficiary is placed on board the ambulance. The rural adjustment would be made using the following methodology:

Rural Adjustment Methodology

- **Ground – 50% add-on to mileage for the first 17 miles and 25% add-on to miles 18 through 50**
- **Air – 50% add-on to the**

- Ground – A 50 percent add-on ($8.21 in 2002) is applied to the mileage payment rate for the first 17 loaded miles, and a 25 percent add-on ($6.84 in

2002) is applied to the mileage payment rate for miles 18 through 50.

- Air – A 50 percent add-on is applied to the base rate and all of the loaded mileage.

Mileage

- **Paid in addition to base payment rate**
- **For 2002**
  - **$5.47 ground**
  - **$6.57 fixed wing**
  - **$17.51 rotary wing**

MILEAGE

Mileage will be paid separately from the base rate.

The mileage rate with the implementation of the fee schedule is as follows:

- $5.47 ground
- $6.57 fixed wing
- $17.51 rotary wing

USING THE FEE SCHEDULE

CMS will provide each intermediary with two files: a national zip code file and a national ambulance fee schedule file. Each intermediary will program a link between the zip code file to determine the locality and the fee schedule file to obtain the fee schedule amount.

The fee schedule locality is based on the point of pickup as identified by the zip code that is coded on the claim form. The intermediary will use the zip code as the point of pickup to crosswalk to the appropriate fee schedule.

Determining Fee Schedule Amounts

When an **urban zip** code is reported with a ground or air ambulance code, determine the amount for the service by using the fee schedule amount for the urban base rate. The mileage amount will be determined by multiplying the number of reported miles by the urban mileage rate.

When a **rural zip** code is reported with a ground HCPCS code the amount for the service will be determined by using the fee schedule amount for the urban base rate. The mileage amount will be determined by multiplying the first 17 loaded miles by the urban mileage rate and then multiplying this by 1.5, multiplying miles 18 through 50 by the urban mileage rate and then multiplying this by 1.25, and multiplying the number of loaded miles in excess of 50 miles by the urban mileage rate, and adding the three mileage amounts.

If a rural zip code is reported with an air HCPCS code, determine the amount for the service by using the fee schedule amount for rural base rate. To determine the amount allowable for the mileage, multiply the number of loaded miles by the rural mileage rate.

2002 FEE SCHEDULE FOR PAYMENT OF AMBULANCE SERVICES

Service level	RVUs	CF	Unadjusted base rate (UBR)H	Amount adjusted by GPCI (70% of UBR)	Amount not adjusted (30% of UBR)	Loaded mileage	Rural ground mileage (miles 1-17)	Rural ground mileage (miles 18-50)*
BLS	1.00	170.54	$170.54	$121.65	$52.14	$5.47	$8.21	$6.84
BLS-Emergency	1.60	170.54	272.86	191.00	81.86	5.47	8.21	6.84
ALS1	1.20	170.54	204.65	143.26	61.40	5.47	8.21	6.84
ALS1-Emergency	1.90	170.54	324.03	226.82	97.21	5.47	8.21	6.84
ALS2	2.75	170.54	468.99	328.29	140.70	5.47	8.21	6.84
SCT	3.25	170.54	554.26	387.98	166.28	5.47	8.21	6.84
PI	1.75	170.54	298.45	208.91	89.54	(1) No Mileage Rate		

Service level	Unadjusted base rate (UBR)	Amount adjusted by GPCI (50% of UBR)	Amount not adjusted (50% of UBR)	Rural air base rate**	Loaded mileage	Rural air mileage***
FW	$2,314.51	$1,157.26	$1,157.26	$3,471.77	$ 6.57	$ 9.86
RW	2,690.96	1,345.48	1,345.48	4,036.44	17.51	26.27

* A 50 percent add-on to the mileage rate (that is, a rate of $8.21 per mile) for each of the first 17 miles identified as rural. A 25 percent add-on to the mileage rate (that is, a rate of $6.84 per mile) for miles 18 through 50 identified as rural. The regular mileage allowance applies for every mile over 50 miles.

** A 50 percent add-on to the air base rate is applied to air trips identified as rural.

*** A 50 percent add-on to the air mileage rate is applied to every mile identified as rural.

The payment rate for rural air ambulance (rural air mileage rate and rural air base rate) is 50 percent more than the corresponding payment rate for urban services (that is, the sum of the base rate adjusted by the geographic adjustment factor and the mileage).

H This column illustrates the payment rates without adjustment by the GPCI. The conversion factor (CF) has been inflated for CY 2002.

Legend for Table 1

ALS1 - Advanced Life Support, Level 1
ALS2 - Advanced Life Support, Level 2
BLS - Basic Life Support
CF - Conversion Factor
FW - Fixed Wing
GPCI - Practice Expense Portion of the Geographic Practice Cost Index from the Physician Fee Schedule
PI - Paramedic ALS intercept
RVUs - Relative Value Units
RW - Rotary Wing
SCT - Specialty Care Transport
UBR - Unadjusted Base Rate

FORMULAS--The amounts in the above chart are used in the following formulas to determine the fee schedule payments--

Ground:

Ground-Urban:
Payment Rate = [(RVU*(0.30+(0.70*GPCI)))*CF]+[MGR*#MILES]

Ground-Rural:
Payment Rate = [(RVU*(0.30+(0.70*GPCI)))*CF]+[(((1+RG1)*MGR)*#MILES≤17)+(((1+RG2)*#MILES18-50+(MGR*#MILES>50)] (Sign before number 17 was erroneously published in the proposed rule.)

Air:

Air-Urban:
Payment Rate = [((UBR*0.50)+((UBR*0.50)*GPCI))]+[MAR*#MILES]

Air-Rural:
Payment Rate = [(1.00+RA)*((UBR*0.50)*GPCI))]+[(1.00+RA)*(MAR*#MILES)]

Legend for Formulas

Symbol	Meaning
#	less than or equal to
□	greater than
*	multiply
CF	conversion factor (ground = $170.54; air = 1.0)
GPCI	practice expense portion of the geographic practice cost index from the physician fee schedule
MAR	mileage air rate (fixed wing rate = 6.57, helicopter rate = 17.51)
MGR	mileage ground rate (5.47)
#MILES	number of miles the beneficiary was transported
#MILES≤	number of miles the beneficiary was transported less than or equal to 17
#MILES18-50	number of miles beneficiary was transported between 18 and 50
#MILES>50	number of miles the beneficiary was transported greater than 50
RA	rural air adjustment factor (0.50 on entire claim)
Rate	maximum allowed rate from ambulance fee schedule
RG1	rural ground adjustment factor amount: first 17 miles (0.50 on first 17 miles)
RG2	rural ground adjustment factor amount: miles 18 through 50 (0.25 on miles 18 through 50)
RVUs	relative value units (from chart)
UBR	the payment rates without adjustment by the GPCI

NOTES: The GPCI is determined by the address (zip code) of the point of pickup.

PAYMENT EXAMPLE

Ground Ambulance, Rural (Hospital Based Provider)

A Medicare beneficiary residing in a rural area in the state of Iowa was transported via ground ambulance from her home located in a rural area (non-MSA) to the nearest appropriate facility (Hospital A). Because the point of pick-up is in a rural area, under our proposal, a rural payment rate would apply. The total distance from the beneficiary's home to Hospital A is 14 miles. A BLS non-emergency transport was furnished. The level of service would be BLS (non-emergency).

For Iowa, the GPCI = 0.876. The ambulance fee schedule amount would be calculated as follows –

14 mile trip = 14 miles at the rural payment rate plus 0 mile at the regular rate.

Payment Rate (per the 2001 fee schedule for Payment of Ambulance Service) =
[(RVU*(.3+(.7*GPCI)))*CF]+[(((1+RG)*MGR)*#MILES≤17)
+(((1+RG2)*MGR)*#MILES18-50)+(MGR*#MILES>50)]

2001 Fee Schedule for Payment of Ambulance Service for BLS non-Emergency

Service Level	RVUs	CF	Unadj. Base rate	Amt. adj. by GCPI	Amt. not adjusted	Loaded mileage	Rural ground Mileage (1-17)	Rural ground Mileage (18-50)
BLS	1.00	170.54	$170.54	$119.38	$51.16	$5.47	$8.24	$6.84

STEP 1: DETERMINE THE PAYMENT RATE

Payment Rate =
[(1.00*(.3+(.7*.876)))*170.54]+[(((1+.5)*5.47)*14)+(((1+.25)
*5.47)*0)+(5.47*0)]
=$270.61

The payment of $270.61 is subject to Part B deductible and coinsurance requirements.

Since 2002 is the first year of a proposed 5-year transition period, the ambulance fee schedule payment rate would be multiplied by 20 percent. The total payment under the proposed fee schedule for 2002 is:

Payment Rate = Fee Schedule * Transition Percentage
Payment Rate = 270.61*0.2
Payment Rate = $54.12

STEP 2: DETERMINE THE TOTAL CHARGE UNDER THE CURRENT SYSTEM

The remaining 80 percent of the payment rate is determined by the current payment system. For FIs, the current payment calculation is as follows:

Assume that Hospital A's charge (HCB) for a BLS non-emergency service is $220.00, its charge for mileage (HCM) is $4.00 per mile, and its past year's cost-to-charge ratio (CCR) is 0.9.

Also assuming that the beneficiary's Medicare Part B deductible has been met, the beneficiary's coinsurance liability for 2002 would be:

Total Charge = HCB+(HCM*#MILES)
Total Charge = 220+(4*14)
Total Charge = $276.00 (Current system)

COINSURANCE CALCULATION

For 2002, the coinsurance is equal to 20 percent of:

Total Rate = (0.80*Current System)+(0.20*FS)
Total Rate = (0.80*276)+(54.12)
Total Rate = 220.80+54.12
Total Rate = $274.92
Coinsurance = 0.20*274.92 = $54.98

STEP 3: DETERMINE THE BLENDED PAYMENT

For 2002, the transition payment rate is equal to:

Transition Payment Rate = [0.80*((HCB)+(HCM* #MILES))*CCR]+[0.20*FS]
Transition Payment Rate = [0.80*((220)+(4*14))*0.9]+[54.12]=$252.84

Assuming the Part B deductible is met:

Medicare Program payment = (transition payment rate) – (coinsurance)
Medicare Program payment = 252.84 – 54.98
Medicare Program payment = $197.86